Nursing Facility Forum Call May 7, 2015

Case Mix Team

Office of MaineCare Services

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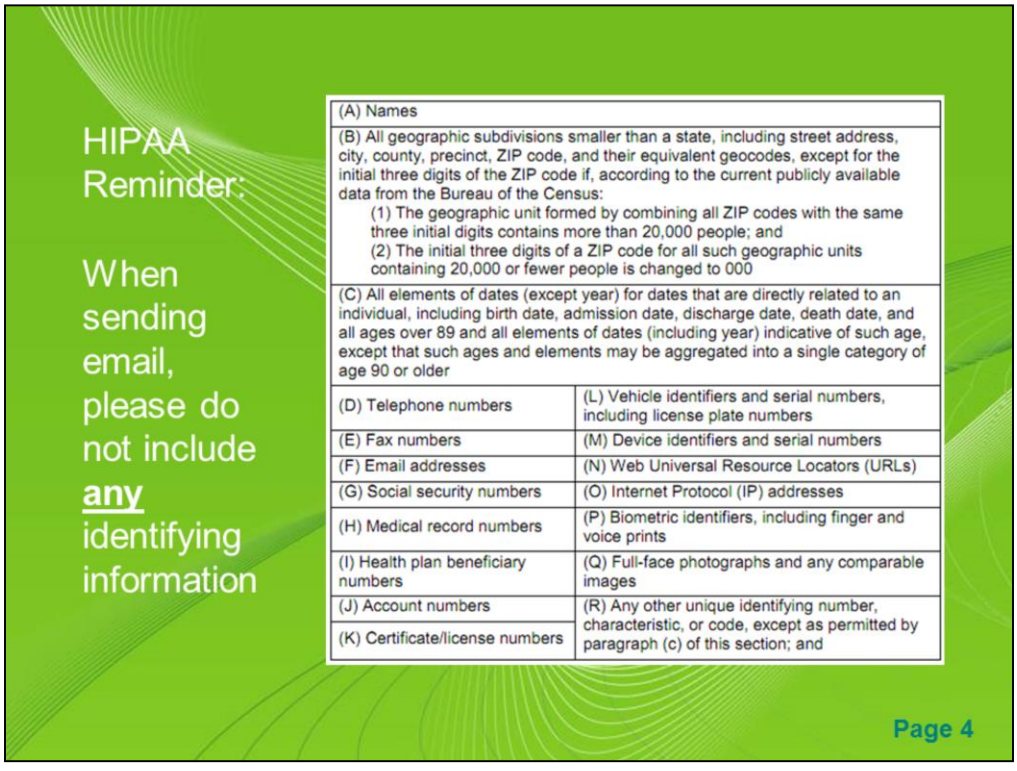
Agenda

- Welcome
- HIPAA Reminder
- Review of Questions/Answers for MDS 3.0
- Section S issue
- Snippet Training: BIMS and Sig Change
- Questions
- Announcements

Welcome to the Spring web-based forum call!

In the lower right hand corner of the screen, you will see a box called "files." These are documents that can be downloaded, and they will also be sent out via email.

There is a Q + A box where you can type in questions if you would prefer to submit a written question rather than ask a question



Protected Health Information (PHI)

Information in any format that identifies the individual, including demographic information collected from an individual that can reasonably be used to identify the individual. Additionally, PHI is information created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual.

De-identified

Information that has certain identifiers (see “identifiers” below) removed in accordance with 45 CFR 164.514; no longer considered to be Protected Health Information.

(Note: Please be aware that individual participants may be identifiable by combing other items in the data een when none of the following 18 identifiers are present. Thus, a study may still contain personally identifiable data (PID) even after removing or never acquiring the identifiers listed below, and the investigator may still need to provide complete answers for the data security questions (Items 8-10) in the protocol.)

Identifiers

Under the HIPAA Privacy Rule “identifiers” include the following: 1. Names

2. Geographic subdivisions smaller than a state (except the first three digits of a zip code if the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people and the initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000).

3. All elements of dates (except year) for dates directly related to an individual, including birth date,admission date, discharge date, and date of death and all ages over 89 and all elements of dates (including year) indicative of such age (except that such ages and elements may be aggregated intoa single category of age 90 or older)

4. Telephone numbers

5. Fax numbers

6. Electronic mail addresses

7. Social security numbers

8. Medical record numbers

9. Health plan beneficiary numbers

10. Account numbers

11. Certificate/license numbers

12. Vehicle identifiers and serial numbers, including license plate numbers

13. Device identifiers and serial numbers

14. Web Universal Resource Locators (URLs)

15. Internet Protocol (IP) address numbers

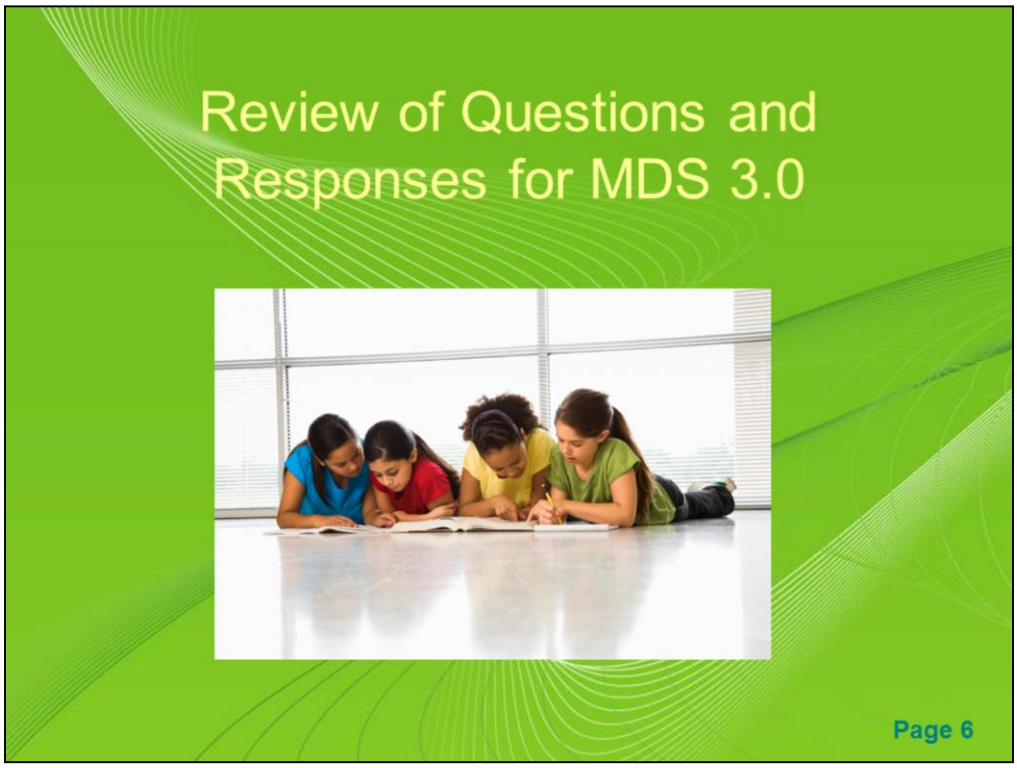
16. Biometric identifiers, including finger and voice prints

17. Full face photographic images and any comparable images

18. Any other unique identifying number, characteristic, or code (excluding a random identifier code for the subject that is not related to or derived from any existing identifier

For more information:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/De-identification/guidance.html

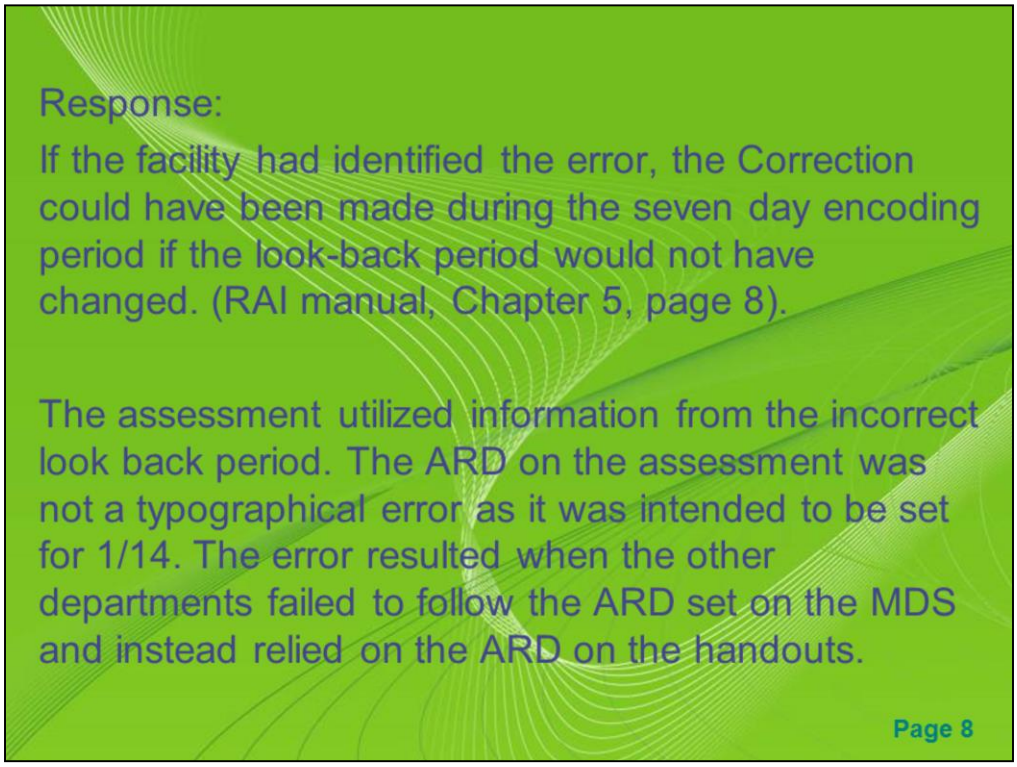


While CMS does not impose specific documentation procedures on nursing homes in completing the RAI, documentation that contributes to identification and communication of a resident's problems, needs, and strengths, that monitors their condition on an on-going basis, and that records treatment and response to treatment, is a matter of good clinical practice and an expectation of trained and licensed health care professionals. Good clinical practice is an expectation of CMS. As such, it is important to note that completion of the MDS does not remove a nursing home's responsibility to document a more detailed assessment of particular issues relevant for a resident. In addition, documentation must substantiate a resident's need for Part A SNF-level services and the response to those services for the Medicare SNF PPS.

Section A

I opened an assessment with an ARD of 1/14. I sent out a list to the various departments with the ARD listed as 1/15. I received a report from therapy with the minutes dated 1/15 and I ran an ADL scores report for 1/15 (instead of the 1/14 on the MDS). I spoke with everyone who does the MDS and they say they rarely look at the ARD on the computer, they use my list.

The error was noted as part of a Case Mix review because the ARD was entered as 1/14 but the information contained in the MDS was based on an ARD of 1/15. If I understand the RAI manual correctly, we should be able to make a correction to the ARD if it falls under the rule of data entry/typographical error.



RAI Manual, Chapter 5, page 8: Changes may be made to the electronic record for any item during the encoding and editing period, provided the response refers to the same observation period.

When the data are encoded into the provider's MDS system from paper, the provider is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during the 7-day encoding period.

Consider the following examples:

• When entering the assessment into the facility's software, the ARD, intended to be 02/12/2013, was inadvertently entered as 02/02/2013. The interdisciplinary team (IDT) completed the assessment based on the ARD of 2/12/2013 (that is, the seven day look back was 2/06/2012 through 2/12/2013. This would be an acceptable use of the modification process to modify the ARD (A2300) to reflect 02/12/2013.

• An assessment was completed by the team and entered into the software based on the ARD of 1/10/2013 (and seven day look back of 1/04/2013 through 1/10/2013). Three weeks later, the IDT determines that the date used represents a date that is not compliant with the PPS schedule and proposes changing the ARD to 1/07/2013. This would alter the look back period and result in a new assessment (rather than correcting a typographical error); this would not be an acceptable

modification and shall not occur.

The error in this case most closely matches the second scenario given in the manual, in which a correction is not allowed as it would change the look-back date.

Section A

A2400. Medicare Stay

Enter Code ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

A2400A: Does this include Medicare Managed Care or just Medicare A?

A2400C: What is the end date? Is it the last covered day or the date of discharge?

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RAI Manual, page A-31:

DEFINITIONS:

MOST RECENT MEDICARE STAY:

This is a Medicare Part A covered stay that has started on or after the most recent admission/entry or reentry to the nursing facility.

MEDICARE-COVERED STAY:

Skilled Nursing Facility stays billable to Medicare Part A. Does not include stays billable to Medicare Advantage HMO plans.

RAI Manual, page A-31

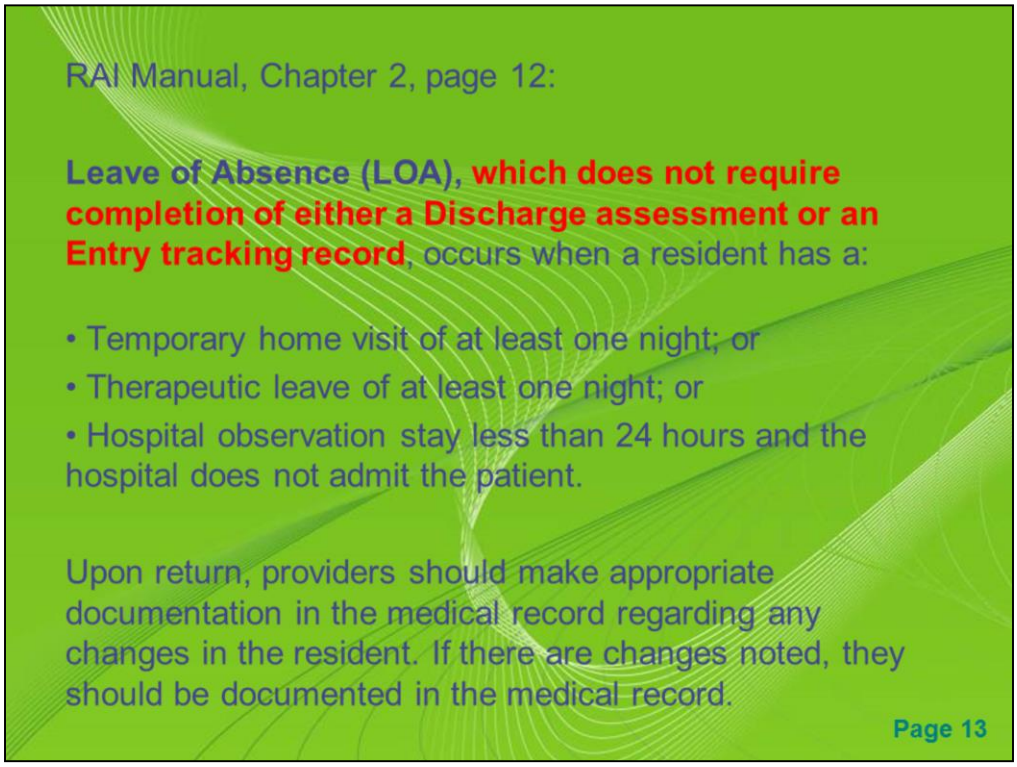
Coding Instructions for A2400C, End Date of Most Recent Medicare Stay:

The end of Medicare date is coded as follows, whichever occurs **first**:

- Date SNF benefit exhausts (i.e., the 100th day of the benefit); or
- Date of last day covered as recorded on the effective date from the Generic Notice; or
- The last paid day of Medicare A when payer source changes to another payer (regardless if the resident was moved to another bed or not); or
- Date the resident was discharged from the facility (see Item A2000, Discharge Date).

Section A

If a skilled resident is sent to the hospital and is kept in an observation bed for less than 24 hours, is the resident discharged?



RAI, Page 2-74: ***Resident is Admitted to an Acute Care Facility and Returns***

If a Medicare Part A resident is admitted to an acute care facility and later returns to the SNF (even if the acute stay facility is less than 24 hours and/or not over midnight) to resume Part A coverage, the Medicare assessment schedule is restarted.

RAI, Page 2-76: ***Resident Is Sent to Acute Care Facility, Not in SNF over Midnight, and Is Not Admitted to Acute Care Facility***

If a resident is out of the facility over a midnight, but for less than 24 hours, and is not admitted to an acute care facility, the Medicare assessment schedule is not restarted. However, there are payment implications: the day preceding the midnight on which the resident was absent from the nursing home is not a covered Part A day. This is known as the “midnight rule.” The Medicare assessment schedule must then be adjusted. The day preceding the midnight is not a covered Part A day and therefore, the Medicare assessment clock is adjusted by skipping that day in calculating when the next Medicare assessment is due. For example, if the resident goes to the emergency room at 10 p.m. Wednesday, day 22 of his Part A stay, and returns at 3 a.m. the next day, Wednesday is not billable to Part A. As a result, the day of his return to the SNF, Thursday, becomes day 22 of his Part A stay.

RAI, Page 2-10: **Discharge** refers to the date a resident leaves the facility. A day

begins at 12:00 a.m. and ends at 11:59 p.m. Regardless of whether discharge occurs at 12:00 a.m. or 11:59 p.m., this date is considered the actual date of discharge. There are two types of discharges – return anticipated and return not anticipated. A Discharge assessment is required with both types of discharges. Section 2.6 provides detailed instructions regarding both discharge types. Any of the following

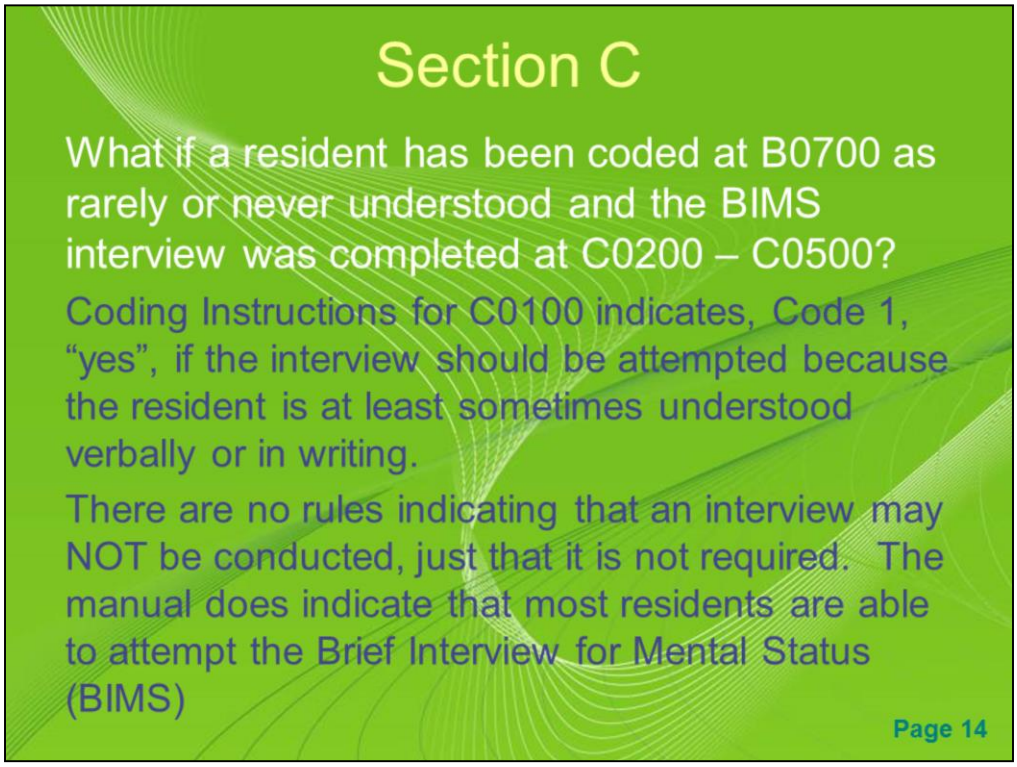
situations warrant a Discharge assessment, regardless of facility policies regarding opening and closing clinical records and bed holds:

• Resident is discharged from the facility to a private residence (as opposed to going on an LOA);

• Resident is admitted to a hospital or other care setting (regardless of whether the nursing home discharges or formally closes the record);

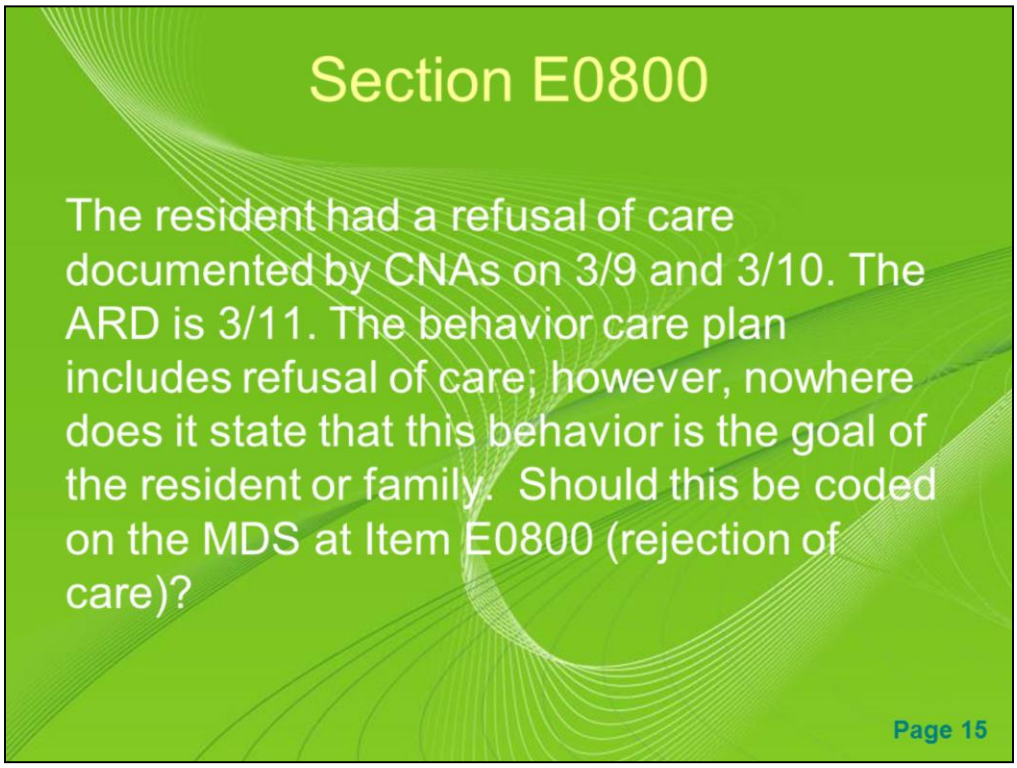
• Resident has a hospital observation stay greater than 24 hours, regardless of whether the hospital admits the resident.

• Resident is transferred from a Medicare- and/or Medicaid-certified bed to a noncertified bed.

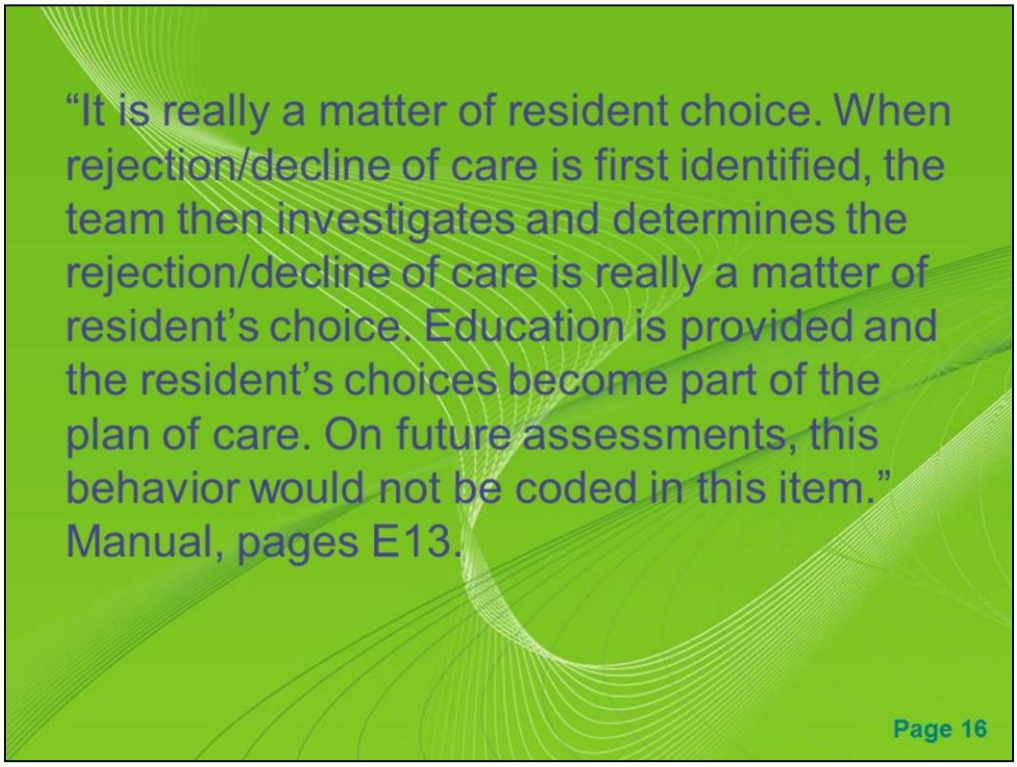


There are no rules indicating that an interview may NOT be conducted, just that it is not required. The manual does indicate that most residents re able to attempt the Brief Interview for Mental Status (BIMS)

Coding Instructions for C0100 indicates, Code 1, "yes", if the interview should be attempted because the resident is at least sometimes understood verbally or in writing.



Bullet #3 above.



DEFINITIONS:

REJECTION OF CARE Behavior that interrupts or interferes with the delivery or receipt of care. Care rejection may be manifested by verbally declining or statements of refusal or through physical behaviors that convey aversion to or result in avoidance of or interfere with the receipt of care.

INTERFERENCE WITH CARE

Hindering the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.

Section K

A resident had a 5% or greater weight loss within the past two weeks and date of admission was two weeks ago. How should this be coded on admission MDS?

RAI Manual, page K-5 :

For a New Admission

1. Ask the resident, family, or significant other about weight loss over the past 30 and 180 days.

Section K

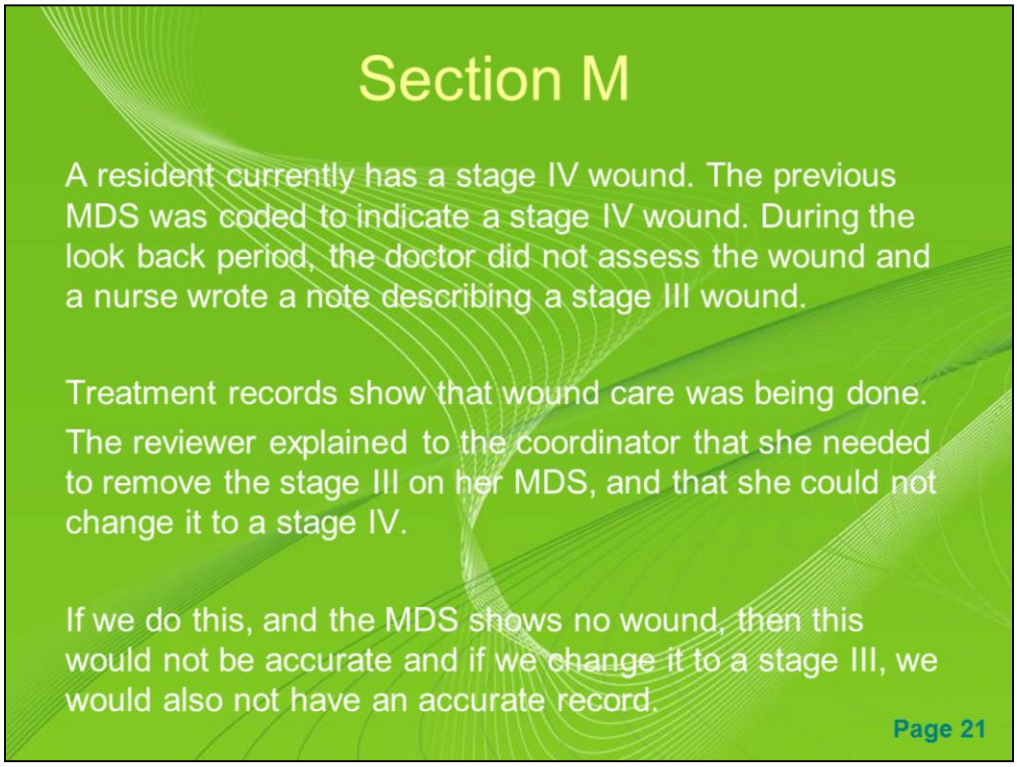
Is diuresis coded as physician-prescribed weight loss?

Yes, (RAI Manual, page K-5) definition of physician prescribed weight loss includes planned diuresis

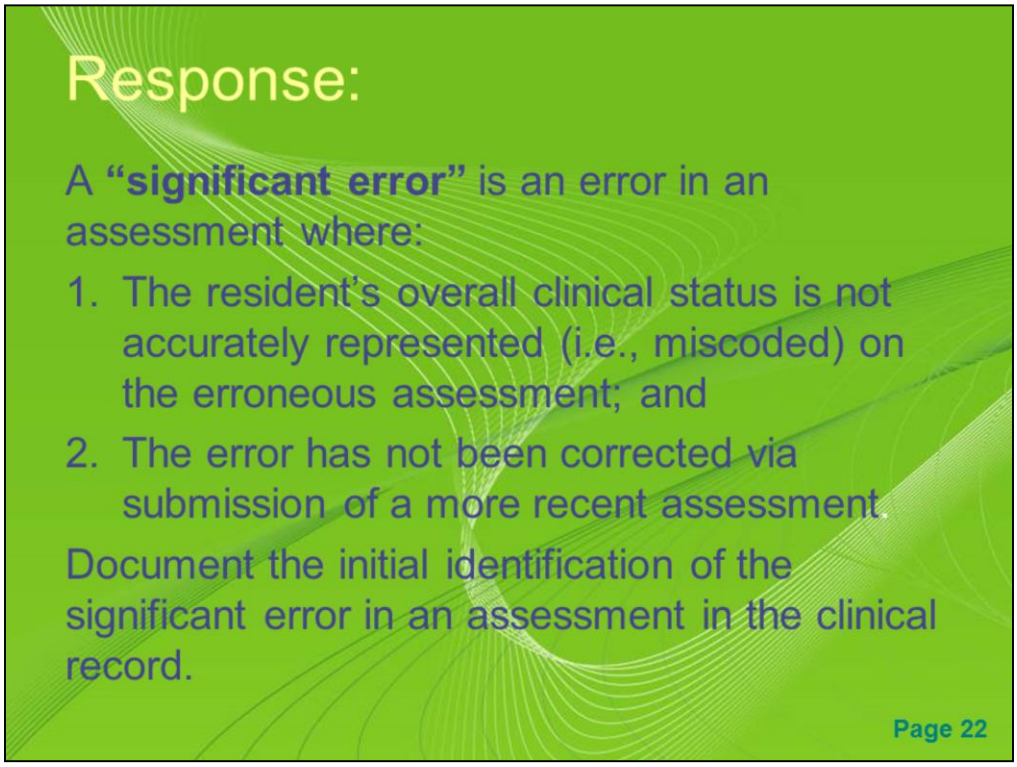
Section J

I am the MDS coordinator in my facility. The Unit Managers code most of the data, and then I complete and sign the MDS. As I was training a new Unit Manager, I looked at an MDS with an ARD of 6/6/14 and noted that a fall had not been coded by the Unit Manager. I had completed and signed off on this MDS. Should I do a significant correction? There was no injury with the fall.

A Significant Correction assessment also is needed because the fall was not on that erroneous assessment to trigger further assessment. Just because the resident wasn't injured does not mean that the fall is not clinically significant. When the Falls CAA triggers, an in-depth assessment of causes, contributing factors, and risk factors must be completed. This will help to determine whether anything has changed for the resident, why the care plan isn't working for this resident, etc. (Rena Shepard)



Coding has to match the documentation.



RAI Manual, Chapter 2, page 28, Significant Correction to Prior Comprehensive Assessment (SCPA), A0310A= 5

In the example given, the assessment had been submitted as an annual (comprehensive) assessment. If it had been a quarterly assessment, the significant correction to a prior quarterly assessment, would be completed.

A SCPA is appropriate when:

- the erroneous comprehensive assessment has been completed and transmitted/submitted into the MDS system; and
- there is **not** a more current assessment in progress or completed that includes a correction to the item(s) in error.
- The ARD must be within 14 days after the determination that a significant error in the prior comprehensive assessment occurred.

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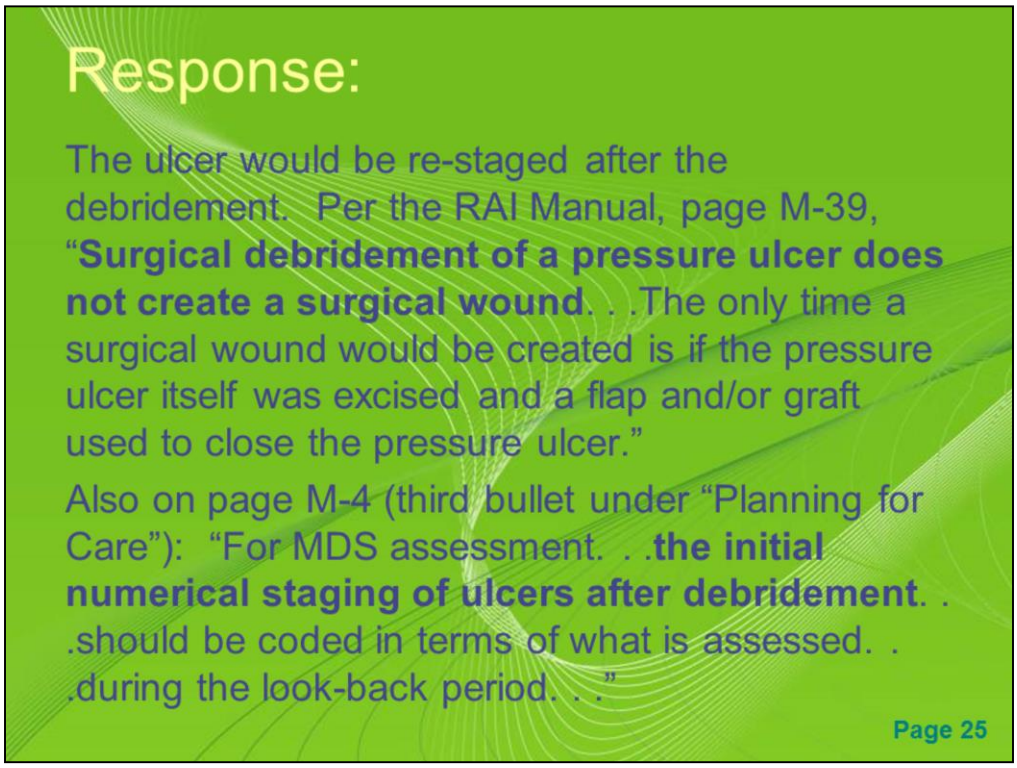
Section M

When a decubitus (actually 2 stage 2's) are surgically debrided, and now presents as one large sacral decubitus, can it be a stage 4 or would it now be a surgical wound?

Page 24



For MDS assessment, initial numerical staging of pressure ulcers and the initial numerical staging of ulcers after debridement,, should be coded in terms of what is assessed (seen or palpated, i.e. visible tissue, palpable bone) during the lookback period. Nursing homes may adopt the NPUAP guidelines in their clinical practice and nursing documentation. However, since CMS has adapted the NPUAP guidelines for MDS purposes, the definitions do not perfectly correlate with each stage as described by NPUAP. Therefore, you cannot use the NPUAP definitions to code the MDS. You must code the MDS according to the instructions in this manual.

Section M

On page M-5 the last two bullets address a healed pressure ulcer. The first bullet states if the pressure ulcer has healed, it is now coded as a healed pressure ulcer. The second bullet states if the pressure ulcer healed during the look-back period, and wasn't present on prior assessment, code 0.

If you code there is no pressure ulcer because it healed during the look-back period, how can you code pressure ulcer care?

Page 26

M0210: Unhealed Pressure Ulcer(s)

Coding Instructions: *Code based on the presence of any pressure ulcer (regardless of stage) in the past 7 days.*

- ***Code 0, no:*** *if the resident did not have a pressure ulcer in the 7-day look-back period.*

Then skip Items M0300–M0800.

- **Code 1, yes: if the resident had any pressure ulcer (Stage 1, 2, 3, 4, or unstageable) in** the 7-day look-back period. Proceed to **Current Number of Unhealed Pressure Ulcers at Each Stage item (M0300).**

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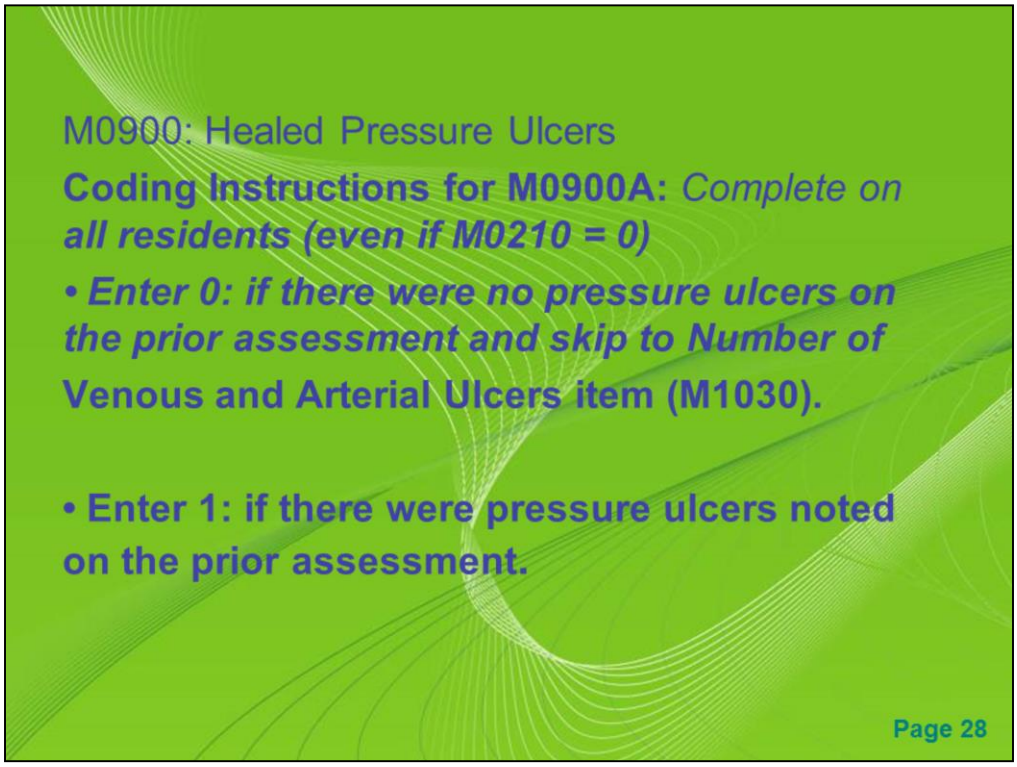
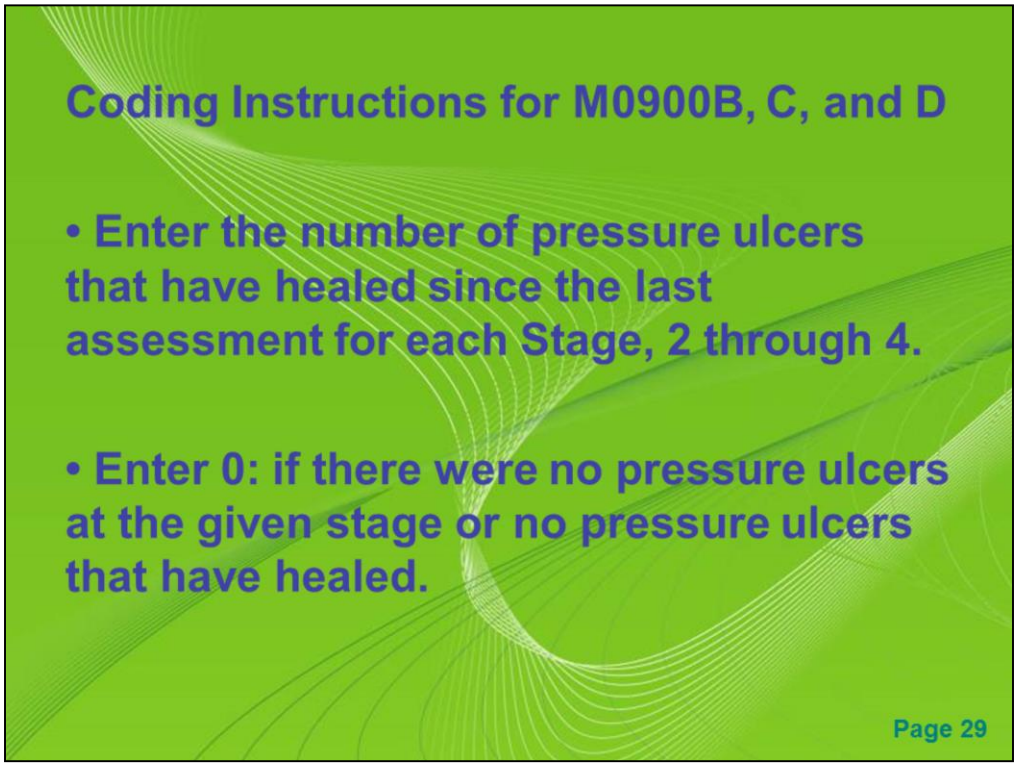
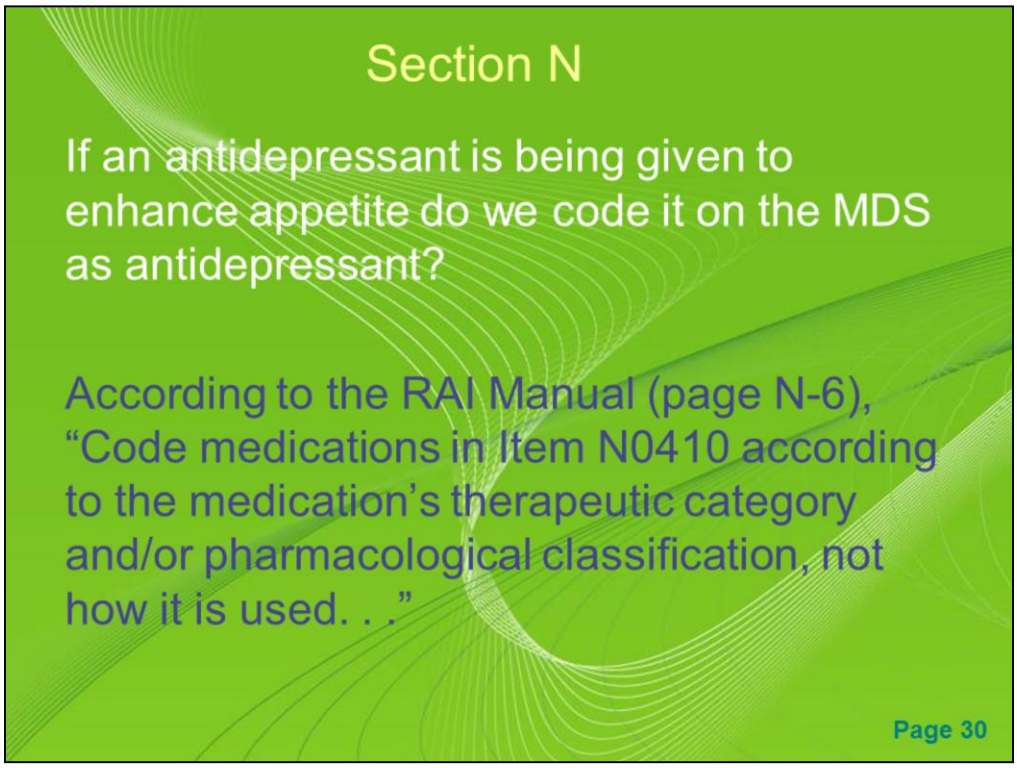


Over time, even though a Stage 4 pressure ulcer has been healing and contracting such that it is less deep, wide, and long, the tissues that were lost (muscle, fat, dermis) will never be replaced with the same type of tissue.

Once a pressure ulcer has healed, it is documented as a healed pressure ulcer at its highest numerical stage – in this example, a healed Stage 4 pressure ulcer. For care planning purposes, this healed Stage 4 pressure ulcer would remain at increased risk for future breakdown or injury and would require continued monitoring and preventative care.



If the prior assessment documents that a pressure ulcer healed between MDS assessments, but another pressure ulcer occurred at the same anatomical location, do **not** consider this pressure ulcer as healed. The re-opened pressure ulcer should be staged at its highest numerical stage until fully healed.



(However, Item O0100A (chemotherapy), is only coded if the chemotherapy was actually used for cancer treatment (page O-2).

Section O

Can a CNA-M administer nebulizer treatment?

Per the Maine State Board of Nursing, a CNA-M cannot administer nebulizer treatments.

Section O

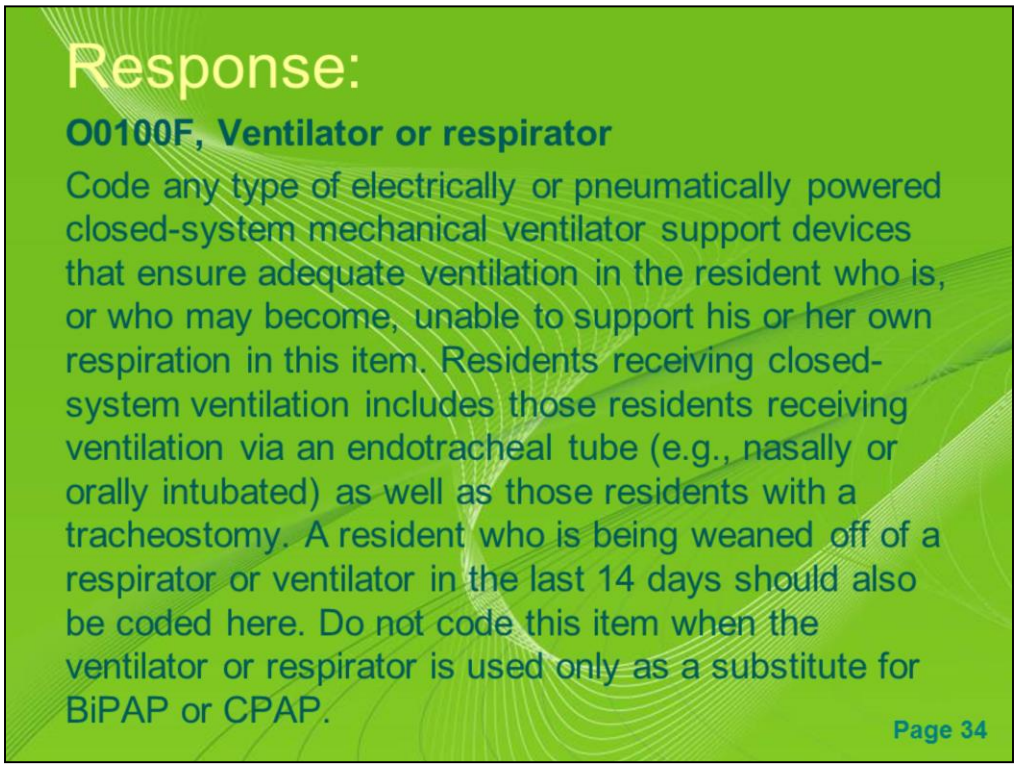
Are we able to count the assessment and orders of a doctor of optometry?

No. According to RAI Manual page O-43 "Includes medical doctors, doctors of osteopathy, podiatrists, dentists, and authorized physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with the physician as allowable by state law." You also cannot count a order written by a PhD Psychologist.

Page 32

Section O

Is a “trilogy ventilator” which is a BiPap and non-invasive can be coded as a ventilator on the MDS?



RAI Manual, page O-3

- There would need to be documentation to support the reason O0100F was coded, i.e. endotracheal tube or tracheostomy and that the device is a closed-system mechanical ventilator support device.

- According to information on the Respironics website, the Trilogy BiPap includes invasive and non-invasive models.

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Section Q

Is there a requirement that the interview for section Q be conducted on the ARD or can it be done within the 7 days before the ARD?

Section Q

There is no reference to a look-back period in Section Q. Appendix D mentions no look-back period for Section Q, so you would follow the instructions in the RAI Manual, "...the standard look-back period for the MDS 3.0 is 7 days, unless otherwise stated" (Manual, page 3-3). Facilities should document when the interview was completed.

Page 37

Section S

I have been told to code S8010 to indicate the resident has a MaineCare co-pay on the 14-day PPS assessment because this assessment covers payment through day 30. Is this correct?

Page 38

Payor Information	
S8010. MaineCare/Medicare Payor	
↓ Check all that apply	
☐	C3. MaineCare per diem payor.
☐	G3. MaineCare as co-pay payor.
S8099. Payor: None of the Above	
↓ Check all that apply	
☐	None of the above

Code S8010 in accordance with the payment source in place on the day of the assessment reference date. On day 14 of a PPS stay, Medicare is covering 100% of the stay. Therefore, S8010 would be left blank and S8099 would be checked.

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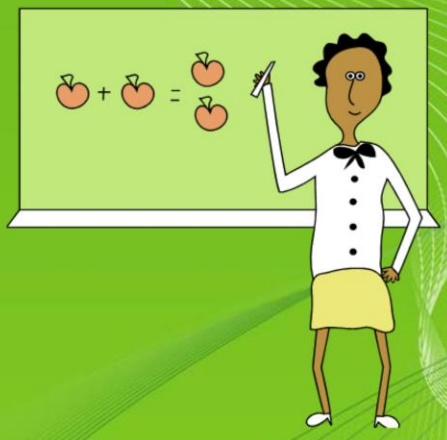
Snippet Training



BIMS
Significant Change

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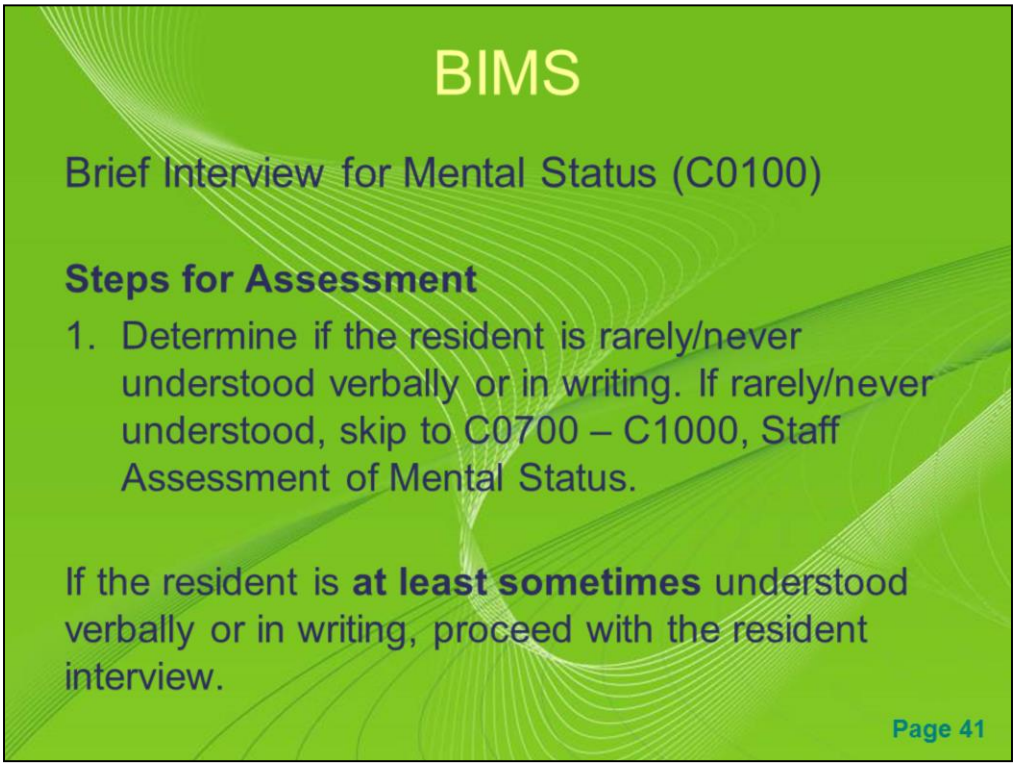


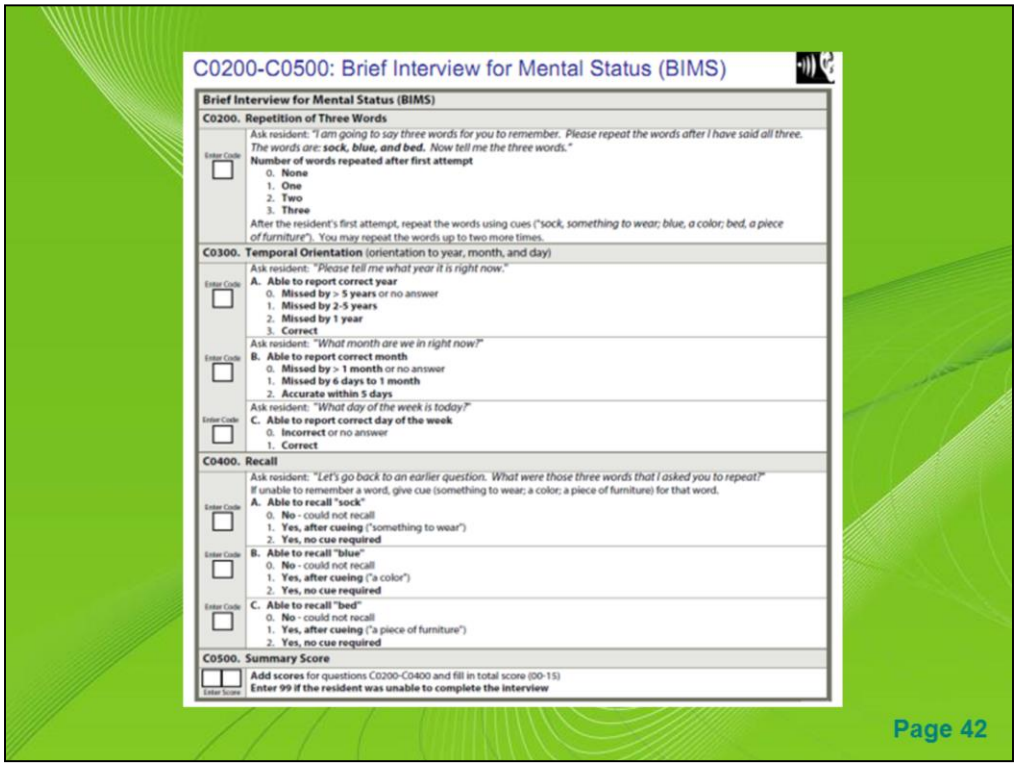
Coding Instructions

Record whether the cognitive interview should be attempted with the resident.

• **Code 0, no:** if the interview should not be attempted because the resident is rarely/never understood, cannot respond verbally or in writing, or an interpreter is needed but not available. Skip to C0700, Staff Assessment of Mental Status.

• **Code 1, yes:** if the interview should be attempted because the resident is at least sometimes understood verbally or in writing, and if an interpreter is needed, one is available. Proceed to C0200, Repetition of Three Words.

If the resident needs an interpreter, every effort should be made to have an interpreter present for the BIMS. If it is not possible for a needed interpreter to participate on the day of the interview, code C0100 = 0 to indicate interview not attempted and complete C0700-C1000, **Staff Assessment of Mental Status, instead of C0200-C0500, Brief Interview for Mental Status.**



Directly ask the resident each item in C0200 through C0400 at one sitting and in the order provided.

If the resident chooses not to answer a particular item, accept his or her refusal and move on to the next questions. For C0200 through C0400, code refusals as incorrect.

Nonsensical responses should be coded as zero.

Rules for stopping the interview before it is complete:

— Stop the interview after completing (C0300C) "Day of the Week" if:

1. all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the item being rated), OR

2. there has been no verbal or written response to any of the questions up to this point, OR

3. there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response.

If the interview is stopped, do the following:

1. Code -, **dash** in C0400A, C0400B, and C0400C.

2. Code **99** in the summary score in C0500.

3. Code 1, yes in **C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? 4. Complete the Staff Assessment for Mental Status.**

When staff identify that the resident's primary method of communication is in written format, the BIMS can be administered in writing. **The administration of the BIMS in writing should be limited to this circumstance.**

• See Appendix E for details regarding how to administer the BIMS in writing.

The BIMS total score is highly correlated with Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) scores. Scores from a carefully conducted BIMS assessment where residents can hear all questions and the resident is not delirious suggest the following distributions:

13-15: cognitively intact

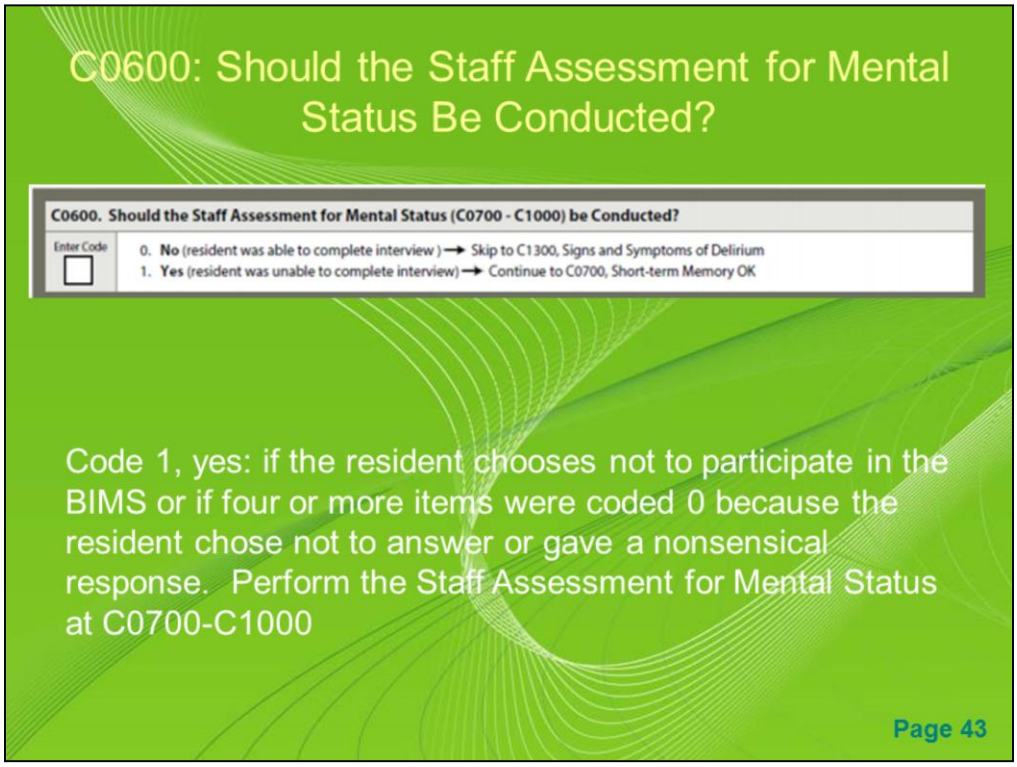
8-12: moderately impaired

0-7: severe impairment

To be considered a completed interview, the resident had to attempt and provide relevant answers to at least four of the questions included in C0200-C0400.

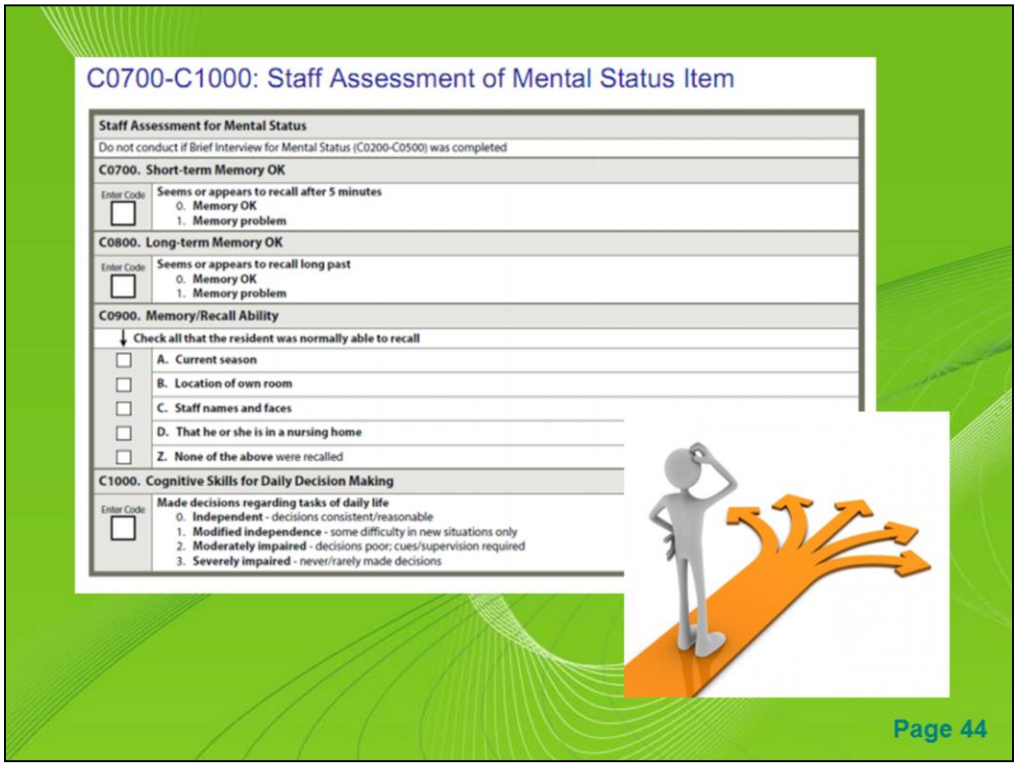
Code 99, unable to complete interview:

Note: a zero score does not mean the BIMS was incomplete



Note: C0500 should be coded 99.

If a resident is scored 00 on C0500, C0700-C1000, Staff Assessment, should not be completed. **00 is a legitimate value for C0500 and indicates that the interview was complete.** To have an incomplete interview, a resident had to choose not to answer or had to give completely unrelated, nonsensical responses to four or more BIMS items.



C0700: Steps for Assessment

Determine the resident's short-term memory status by asking him or her:

- to describe an event 5 minutes after it occurred if you can validate the resident's response, or
- to follow through on a direction given 5 minutes earlier.

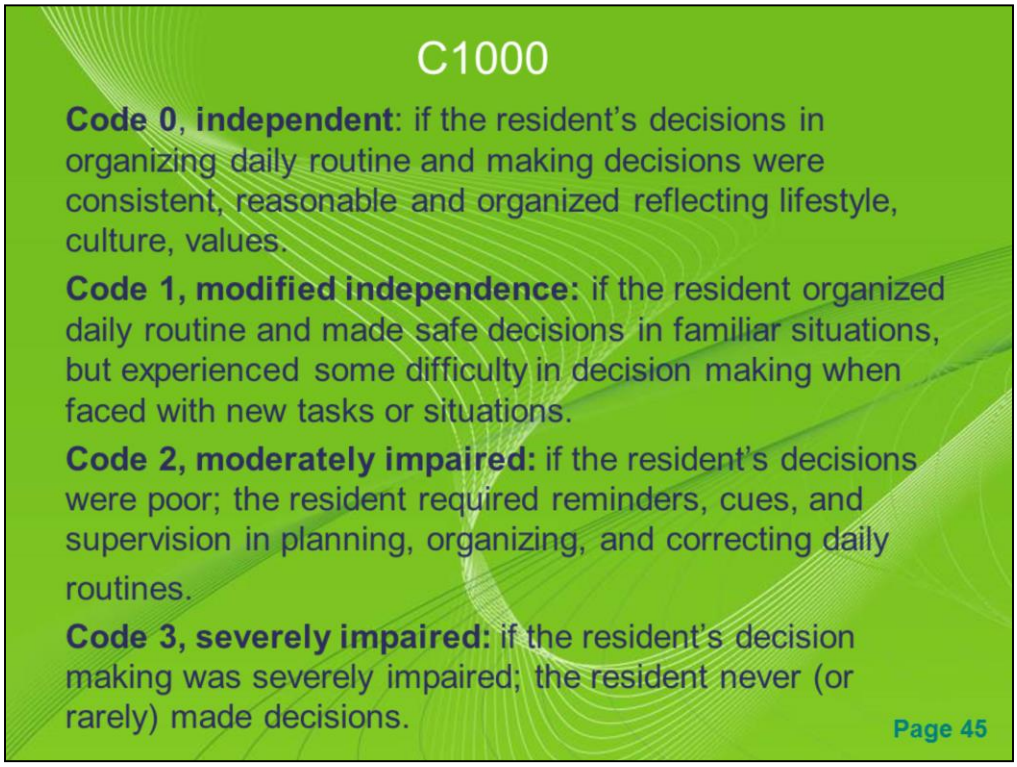
Observe how often the resident has to be re-oriented to an activity or instructions.

C0800: Long-term Memory

Determine resident's long-term memory status by engaging in conversation, reviewing memorabilia (photographs, memory books, keepsakes, videos, or other recordings that are meaningful to the resident) with the resident or observing response to family who visit.

- Ask questions for which you can validate the answers from review of the medical record, general knowledge, the resident's family, etc.
- Ask the resident, "Are you married?" "What is your spouse's name?" "Do you have any children?" "How many?" "When is your birthday?"

- Observations should be made by staff across all shifts and departments and others with close contact with the resident.
- Ask direct care staff across all shifts and family or significant others about the resident's short-term memory status.
- Review the medical record for clues to the resident's short-term memory during the look-back period.



DEFINITION : DAILY DECISION MAKING

Includes: choosing clothing; knowing when to go to meals; using environmental cues to organize and plan (e.g., clocks, calendars, posted event notices); in the absence of environmental cues, seeking information appropriately (i.e. not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations to regulate the day's events (e.g., asks for help when necessary); acknowledging need to use appropriate assistive equipment such as a walker.

If the resident makes decisions, although poorly, code 2, moderately impaired.

Examples: RAI, Page C-24

Significant Change

Significant Change in Status (SCSA) (Comprehensive)	A0310A= 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD ÷ 6 previous calendar days	ARD ÷ 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with another assessment

The above screenshot is taken from the RAI manual, Chapter 2, page 2-15.

- If a resident goes to the hospital prior to completion of the OBRA Admission assessment, when the resident returns, the nursing home must consider the resident as a new admission. The nursing home may not complete a Significant Change in Status Assessment until after an OBRA Admission assessment has been completed.

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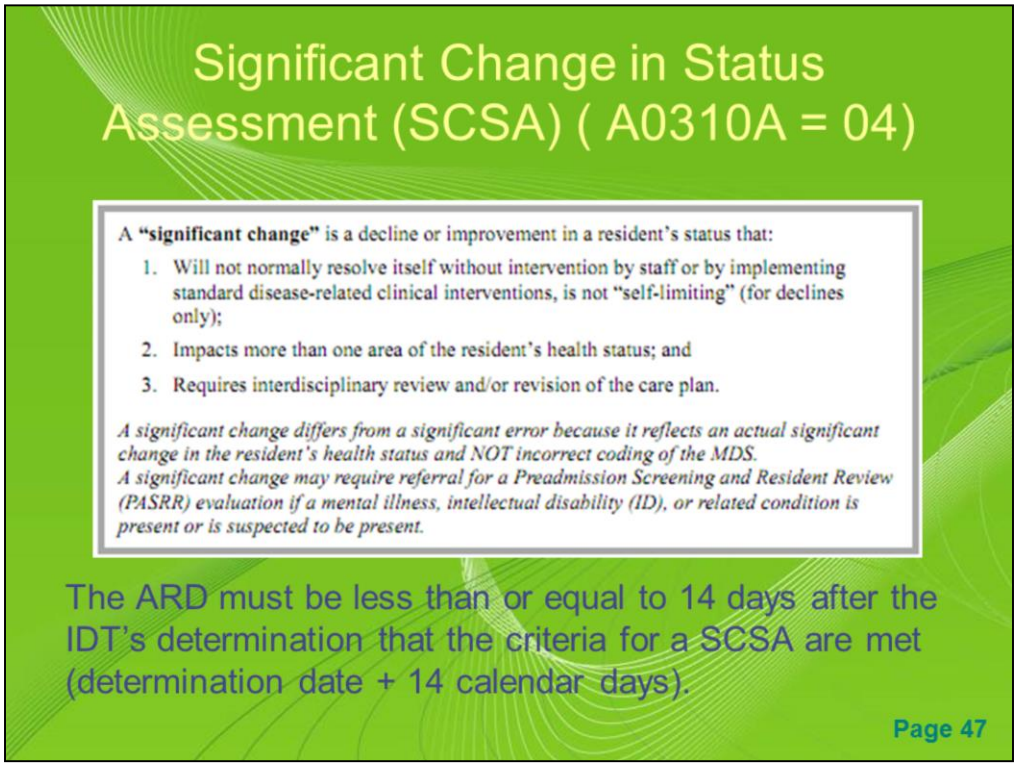

When a resident's status changes and it is not clear whether the resident meets the SCSA guidelines, the nursing home may take up to 14 days to determine whether the criteria are met.

A SCSA is appropriate when:

— There is a determination that a significant change (either improvement or decline) in a

resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and

— The resident's condition is not expected to return to baseline within two weeks.

— For a resident who goes in and out of the facility on a relatively frequent basis and

reentry is expected within the next 30 days, the resident may be discharged with return anticipated. This status requires an Entry tracking record each time the resident returns to the facility and a Discharge assessment each time the resident is discharged. However, if the IDT determines that the resident would benefit from a Significant Change in Status Assessment during the intervening period, the staff must complete a SCSA. This is only allowed when the resident has had an OBRA

Admission assessment completed and submitted prior to discharge return anticipated (and resident returns within 30 days) or when the OBRA Admission assessment is combined with the discharge return anticipated assessment (and resident returns within 30 days).

-- Enrollment or unenrollment in a hospice program, whether the program is provided under Medicare, MaineCare or other payer source.

If there is only one change, staff may still decide that the resident would benefit from a SCSA. It is important to remember that each resident's situation is unique and the IDT must make the decision as to whether or not the resident will benefit from a SCSA. Nursing homes must document a rationale, in the resident's medical record, for completing a SCSA that does not meet the criteria for completion.

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Decline in two or more of the following:

- Resident's decision-making changes;
- Presence of a resident mood item not previously reported by the resident or staff and/or an increase in the symptom frequency (PHQ-9©),
- Any decline in an ADL physical functioning area where a resident is newly coded as Extensive assistance, Total dependence, or Activity did not occur since last assessment;
- Resident's incontinence pattern changes or there was placement of an indwelling catheter;

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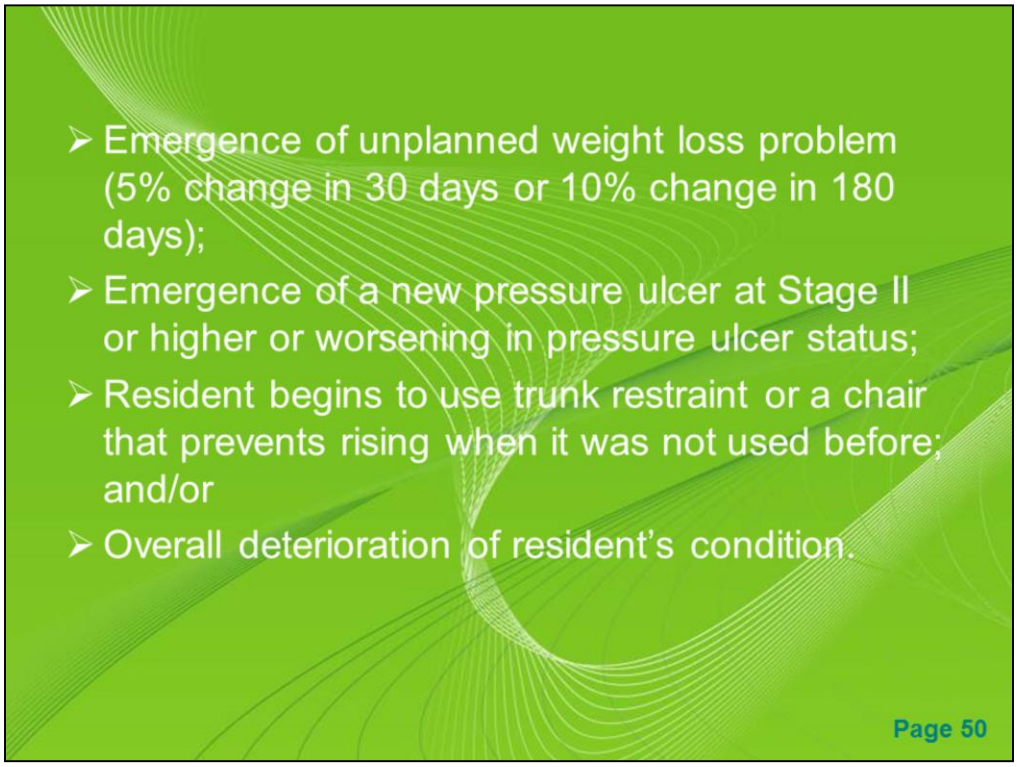
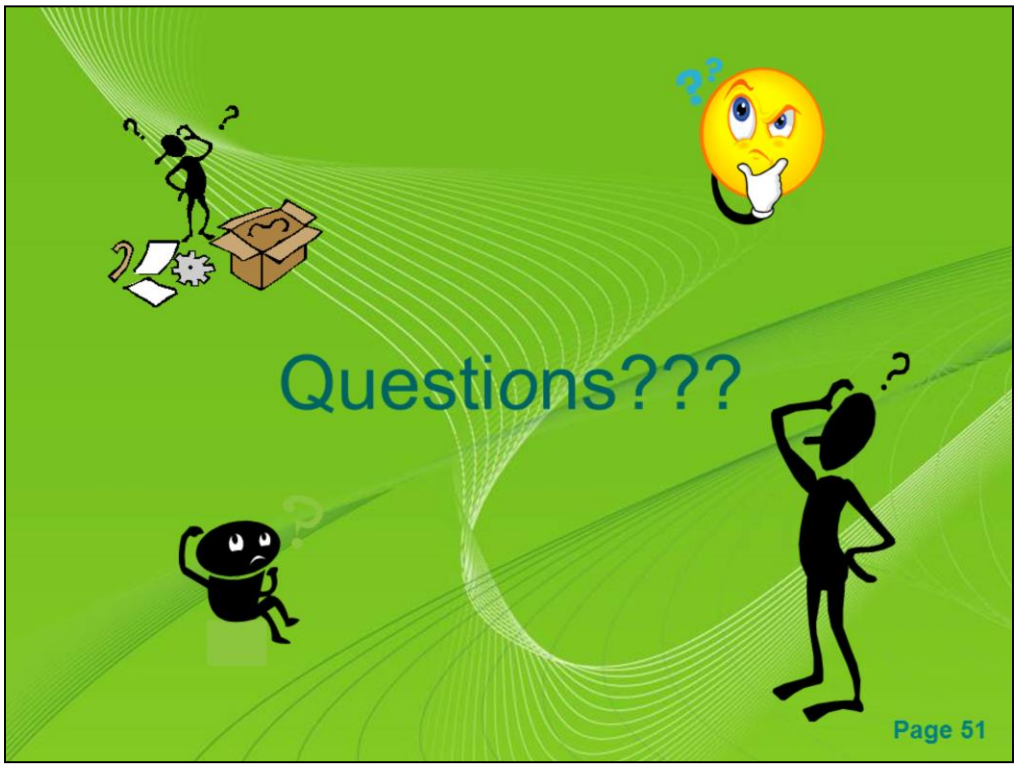


Extra quarterly assessments are not allowed in Maine, according to the ManeCare Benefits Manual. Significant change is not a substitute for an extra quarterly.

RAI Manual, Chapter 2, pages 2-20 to 2-27 for more information on significant changes.


Questions???
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Announcements and Reminders:

- New Toll Free Help Desk number:
  1-844-288-1612
- Please do NOT send protected health information (PHI) via email unless the email is encrypted.
- Upcoming MDS 3.0 Training:
  5/13/15 Biddeford
  6/26/15 Augusta
  July TBD – Lewiston
  Augusta TBD - Caribou
- Next call: August 6, 2015

Contact Information

- MDS Help Desk: 624-4019

New! → **toll free: 1-844-288-1612**
MDS3.0.DHHS@maine.gov

- Lois Bourque RN: 592-5909
  Lois.Bourque@maine.gov
- Heidi Coombe RN: 441-6754
  Heidi.L.Coombe@maine.gov
- Darlene Scott-Rairdon RN: 215-4797
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